AMCHP Annual Conference, 2010

Moving Ahead Together:

Celebrating the Legacy, Shaping the Future of Maternal and Child Health

Plenary IV:

What's the Role of Home Visitation in Maternal and Child Health Programs of the Future?

March 6-10, 2010

JANED: Yeah, we have one daughter. Eva Isabelle **** you can tell we're from Hawaii.

INTERVIEWER: And what happened?

SPEAKER: Well, she has a, Janed and I are both carriers of the SME gene, and we didn't know prior to her being born, I had a normal pregnancy, normal birth, and she was about five-and-a-half months old when she was diagnosed and then we ended up in the hospital for about six months with her first cold and that's when we kind of needed to have her on mechanical support and she has, she's fed through a G-tube, and so we have nursing care for her in the home.

First thing we did is cry a lot, because her condition is actually terminal. Most kids with her type of SMA don't usually live past the age of two, and she's five-and-a-half now, but we, we went into the hospital, right before that, we were trying to see if there was anything else we could do to try to help prolong her life and see if we could give her a better quality of life, and we ended up—

JANED: By the time we found out, there wasn't much time to think, because the next step was, she was already in the hospital. We were on the bedside.

INTERVIEWER: Right.

JANED: We were on the bedside, on the internet, we were looking on the internet, we were calling anybody that, you know, we knew that maybe could help. My wife got books, she started reading.

INTERVIEWER: Support group?

JANED: We were looking for support groups, anything at that point, because the doctors, they weren't helping, they already knew, okay, there's nothing we really can do, and next. So, you know, we had to take it upon ourselves to figure out, okay, what we want to do, yeah. And we prayed a lot, and you know, it's five-and-a-half years later and she's doing great, you know?

SPEAKER: And so, we had, I mean, all we had was basically our insured, health insurance coverage from his job. Because at the time, I wasn't working—I was working, but, I was on maternity before I even found out about all of this and by the time I went back to work, is when we really, all of this started happening, so I ended up having to quit my job.

JANED: Leave, yeah.

SPEAKER: So I lost my healthcare coverage and I had to go under him as a family plan. But then his coverage doesn't cover everything, so, you know, I had to start calling everybody in the phone book to find out what kind of services we were eligible for, eligible for and what we would do to, you know, help us, because we only had one income now.

I say it was always kind of a blessing in disguise that we ended up in the hospital—

JANED: For that length of time.

INTERVIEWER: ****

SPEAKER: Six months.

INTERVIEWER: Wow.

SPEAKER: We were, she went in when she was five-and-a-half months, and we came out right before her first birthday. And part of it was because, you know, with difficulty trying to arrange nursing care, because they wouldn't release us unless they knew we had enough support at home.

JANED: Right.

SPEAKER: And, you know, if it wasn't for the case managers in the hospital and outside telling them that, you know, we're very confident that this family can go home on their own, we probably would've still been there, you know.

JANED: Because nobody had.

SPEAKER: Nurses.

JANED: And there was equipment that Hawaii didn't even have on the island until Eva was born and we requested, you know, certain doctors from New Jersey to come over, fly over and bring the equipment. And now, most hospitals have it in Hawaii. You know, it's called a cough assist and it helps the child cough, like how we normally clean ourself out, it does that, you know? And then that's part of her treatment every day and that's a big thing that keeps her cleaned and healthy, I think, yeah.

SPEAKER: Well, I think having a parent line, hotline to call for anything, I mean, that's one of the things that we've tried to develop as a family to family health information center in Hawaii. We have a phone number that you can call, and you know, we'll talk to you and see how we can work out anything for you. Because, you know, with some of the healthcare insurances, its qualifications are sticky and some people may or may not

qualify, but there's also other options that we can help them with, but they don't know about that.

JANED: So I would say knowing that they're not the only ones in the situation, you know? Knowing that there's somebody there, another family that went through the exact same thing, that is still going through it, but knows how to navigate through whatever system we have to try and get the services that they need, yeah? We've been there, we're still going through it, let us help you. That, to me, would make somebody feel a little at ease of what they're going through because, whew, I'm not alone, you know? So I think that's important.

Keep fighting for the kids and for the family unit, you know?

[APPLAUSE]

NAN STREETER: Good morning and welcome back. I'm not Phyllis today. I'm Nan Streeter, I'm the Title V Director in the State of Utah and the past president of the AMCHP Board and it's really, this is going to be a great session and I think the story of Eva reminds us how important family supports are and how much we need to involve families in our work. We have done so much, but we have so much more to do, as we all know.

In honor of all the parents and family members who are here at the conference, I'd like to ask all the parent representatives, family scholars, and other family leaders who are here to please stand and be recognized for your efforts to help families like Eva's parents.

[APPLAUSE]

NAN STREETER: Thank you, and it's so great to see so many of you here with us, and I think all the stories that we've heard every morning have been extremely touching. We have a special recognition that we want to share with you. Today is the birthday of a good friend of AMCHP 's, Ms. Katie Beckett.

[APPLAUSE]

NAN STREETER: Katie and her mom, Julie, worked tirelessly, I can't say it, my tongue is—worked very hard, for the passage of what we now call the home and community-based waiver program, often called the Katie Beckett Waiver Program.

The Katie Beckett Waiver Program was the new standard, or created a new standard, that allowed kids who were forced to be institutionalized or hospitalized, many on assistive technology, to be treated at home by keeping them eligible for Medicaid by waiving their family income, since that income could not or would not cover the cost of

their care at home and would be waived if they remained in an institutional setting, rather than at home.

This new program has helped over a half a million people with disabilities, especially kids, to live in their homes and communities. Katie, you're here, Julie, your mom is here, and I would like to ask Mike Frazier to lead us in a round of Happy Birthday for Katie.

[AUDIENCE SINGS AND APPLAUSE]

NAN STREETER: And many more! I have to say that I had heard about the Katie Beckett waiver a number of years ago and had no sense of the commitment that Katie and Julie have had to making this happen. And when I first met them, I was just in awe because I'd always heard about Julie Beckett and Katie Beckett and it's been so nice to get to know you over the past couple of years. So thank you, I know all the families that are here who have kids who have disabilities that otherwise would be, you know, require institutionalization or hospitalization really appreciate all the work that you put in to make this happen. So thank you so much.

[APPLAUSE]

NAN STREETER: Well, on with the program. So, I have the great opportunity to introduce a wonderful and relevant session on home visiting and MCH. We've been on a roller coaster ride with healthcare reform, sometimes it's up, sometimes it's down,

sometimes it's nowhere. And the support for home visiting programs has been riding the ups and downs as well, and as the healthcare reform legislation progresses, we hope to learn more, more specifics about the home visiting aspect of healthcare reform.

Now, when this session was put together, AMCHP thought that our federal partners, who I'll introduce in a second, that they were providing us with information about guidance, how to apply for funds, you know, what kinds of programs and so on and so forth, but we're not there yet, but we're going to get there.

So I think that it's great that Title V has been seen as a home for new investments, or a potential home for new investments and home visiting. And the Senate Health Reform Bill firmly establishes the new Federal Home Visitation Programs as a co-led activity between both HRSA, MCHB, and colleagues at ACF, the Administration for Children and Families.

In the senate bill, there's a tremendous investment, $1.5 billion over five years for evidence-based home visitation in the states. And with that investment are many opportunities and challenges for those of us running MCH programs. So today we're going to talk about some of the issues involved in the proposed home visitation program and then get to know a little bit more about the various models that are out there.

Will the bill pass? We'll talk about that at lunch during our healthcare reform panel, and regardless, the attention on home visitation and as leaders, we need to know more about home visitation and the opportunities and challenges that it presents to us.

So like we did at lunch yesterday, we will hear from two public health leaders, this time representatives from the two agencies that may be charged with co-leading new home visitation programs, but currently administering related programs, and then we'll hear from a panel of leaders who represent the five major home visiting models and what a treat, I think, you will find in learning more about their programs.

So to start with, I would like to ask Audrey Yall to share some of the work she's been doing at the MCH Bureau. Audrey has been a great friend of AMCHP and we're very pleased that she was named the point person for home visitation at the Bureau.

Audrey, will you join me?

AUDREY YOWELL: Thanks, Nan. As has been pointed out, when I was first asked to come to speak to you, we thought we were going to have something specific to speak about. Well, we don't. So my remarks will be brief and since I have been besieged with questions since I arrived, I've decided to do this in the form of an FAQ.

So first, where did this whole idea of home visiting come from anyway and why is it phrased the way it is in the legislation?

Well, the support for evidence-based home visiting programs emerged as a priority for President Obama as a component of health reform.

So, what are we, Maternal and Child Health Bureau, and the State Title V Programs together, doing related to help home visiting?

Well, everything. I mean, if you consider that home visiting programs aim for healthy pregnancies and birth outcomes and healthy mothers, children, and families, all our programs are related, everything that you do. More specifically, home visiting is included as part of Healthy Start and the Early Childhood Comprehensive Systems Program, ECCS, strategically renamed as you may recall, from Stay ECCS, or SEC, some years ago, also incorporates home visiting as one of its components. In fact, Title V legislation encourages home visiting and as you know, many states are using the block grant to support a broad array of home visiting programs in whole or in combination with support from other sources such as TANF and Medicaid.

Title V also serves an important convening role, and it brings together a variety of related agencies and professionals to work together to support comprehensive services.

Q: Well, what does MCHB doing about the National Home Visiting Program? That's what you all want to know, right? Do we have the answers that we haven't shared with you yet?

Well, no. What we're doing is we're getting ready and we're continuing to get ready, and we're getting ready, and we do realize that you would like Katherine and me to tell you today what a national home visiting program initiative would be like and what kinds of programs it will support, but as you know, there are actually two versions of the legislation that are pending, one in the House and one in the Senate, and they're some major and minor differences between them.

So who knows if health reform will pass and if it does, what the final laws, including home visiting programming, is going to look like. It might be like one version, like another version, or something completely different. We don't even know which agency, presumably ACF or HRSA MCHB, is going to be responsible for administering it.

But what we can do, and we are doing is, number one, we're working within the Bureau to identify issues to be alert and to prepare for a quick start-up if and when a program is passed.

But even more important, regardless of which agency is the lead, ACF, MCHB, and other federal agencies are going to have to work together if an effective, comprehensive initiative is to succeed and in fact, we're partnering and planning with ACF and other federal agencies to continue a tradition of collaboration that begin with Healthy Child Care America, ACCS, Oral Health, and other programs.

As many of you know, in anticipation of a home visiting program, Mathematica Policy and Research has a contract with ACF with additional support from the Bureau, to review the evidence-base for home visiting programs. And you may recall receiving a call for papers in relation to this study several months ago.

Beyond that, MCHB is partnering with ACF, including with Katherine, who's going to be speaking to you in a moment, as well as CDC, the Offices of the Secretary and the Assistant Secretary, and other agencies, on a home visiting programmatic issues workgroup to consider potential program implementation issues.

So what can you do to prepare? Well, first, I would strongly suggest that you read both final pieces of legislation, which you can find online, and you'll see that they share some common themes, state needs assessment, evidence-based programming, maintenance of effort, and coordination of resources and linkages. You can start thinking about how your state can be ready for whatever form of home visiting, if any, becomes law, because if this does pass, there's not going to be much turnaround time.

And my last piece of advice is, get ready, get ready. Thank you.

NAN STREETER: Thank you, Audrey. Course the challenge of getting ready is, we're not sure what we're getting ready for, and that's a challenge both for the federal agencies, as well as for states. And, you know, we always keep saying, you know, this

is what will solve our problem, is money, money. But sometimes you have to be careful what you ask for.

All right, it's my pleasure now to introduce Katherine Nolan from ACF. Katherine is a wonderful resource for us at ACF and works closely with the program to evaluate home visitation programs in several states.

Katherine, welcome to AMCHP.

CATHERINE NOLAN: Thank you, Nan. Wow, those lights are bright. Well, good morning everyone. It is really an honor to be asked to be here with you today. I am the Director of the Office on Child Abuse and Neglect, which is an office that is housed with the Children's Bureau at ACF. Do any of you know or are you familiar with the Children's Bureau?

Okay, we are the oldest federal agency solely dedicated to the welfare of children and I was joking with Mike the other day when we were talking about preparations for today. Home visiting is nothing new. The very first commissioner of the Children's Bureau is a woman named Julia Lathrop. Julia was appointed as the first commissioner by President Taft in 1912. And so we are looking to forward our 100th birthday in 2012, but the point of talking about her here is that when she first looked at what her agenda would be as the first commissioner, one of the things that she was looking at was infant

mortality, services to pregnant women, the child labor laws, in fact, the Children's Bureau was first housed in the Department of Labor in 1912.

But one of the vehicles that she felt very strongly about in terms of trying to address some of the social issues of the day was home visiting. So we have a nearly 100-year history of working with this issue in the Children's Bureau.

Something I wanted to tell you about, just in terms of my office, my office was created by the Child Abuse Prevention and Treatment Act of 1996. We used to be the National Center on Child Abuse and Neglect, that legislation did away with the Center and instead said an office on child abuse and neglect may be created, or the duties of the law could be carried out by existing entities. So after a good year-and-a-half of deliberations, the decision was made to create my office and to house it within the Children's Bureau. So we've been in existence since April of 1998.

One of the things the law says is that my office is responsible for interagency collaboration and coordination across the department on any issues related to child maltreatment and specifically the prevention of child abuse and neglect and I have to say, as Director, I have taken that very seriously and my staff does also. And I think we're very fortunate to have that language, because we believe that interagency collaboration and coordination is the way to go anyway, but it's nice to have that legislative mandate to sort of back us up in our work.

So there's a longstanding federal interagency workgroup on child abuse and neglect and again, that was first mandated with the early days of CAPTA in the mid 1970's. The mandate went away, but the people meeting every quarter decided that they wanted to keep it going. So basically this group has been meeting once a quarter since the mid '70's and I think that's our best example of longstanding federal interagency collaboration and coordination.

When we look specifically at prevention, we have kind of a multi-pronged approach within OCAN. We have sort of four key areas of activity, one is supporting state and local prevention activities through our CBCAP program. CBCAP is title 2 of CAPTA, Community Based Child Abuse Prevention Program, and the last few years it's been pretty much level funded at around $47 million. And basically, it's not a block grant, like what Audrey was just describing, it's called a formula grant, and essentially every state that applies gets a base of $200,000 and then a certain amount based on the number of children in the state, and then there's a small amount which we call leverage claim or incentive, where a state can submit to us information on how much non-federal money they spent for prevention activities in the preceding year, and we can give them a little bit of a bonus for that.

So all the states, Puerto Rico, and DC, do get the CBCAP funds and in the legislation a couple years ago, in 2003, a voluntary home visiting was added as a core service. There are about seven core services listed in the language, and home visiting was added to that list.

If you follow any of our work, you may know that we are really invested in building on what we learned from the field and from the practice community, as well as the research community, about building an evidence base. How do we know that what we're funding is worth funding and that we'll get good results from those projects? So I'll talk with you in a little more detail about that, but the second piece is building on the evidence base regarding effective prevention programs.

The third piece is providing education and awareness at the national level. You may know that April is Child Abuse Prevention Month and every year we work with our national prevention partners, many of whom are here at the table this morning, to create a community resource guide for communities to use with their education and awareness campaigns for the month of April.

And then finally, as I say, our fourth area of activity is really to enhance our federal partnerships and collaboration.

I mentioned the Federal Interagency Workgroup, several years ago there was also a partners group that was created, an early childhood systems building group, and I would say that probably that is the most direct linkage that my office has with HRSA and MCHB, working with those early childhood systems development projects.

Okay. I don't think we have enough time to go through all of this. I think, suffice it to say, we have a long history of supporting prevention projects through our discretionary grant program, in addition to the formula grant that I just mentioned, and the two that are current, that are most relevant to this discussion are, in 2007, using CAPTA funds, we funded three evidence-based nurse home visiting projects, and then in 2008, I'm sure many of you are aware of the work we've done, we got additional money through CAPTA to aware 17 projects across the country in 15 states on evidence-based home visiting. Unfortunately, we're going through a bit of a rough patch right now, because as Audrey said, you know, and you never know what's happening with the budget until the midnight hour, we thought for sure that the funding was guaranteed and literally at the midnight hour, because of the proposed healthcare reform, the funding for that project was taken away very unexpectedly. So we've been screwing around, trying to work with our federal partners and within the Children's Bureau itself to see if we can't pull together at least some funding to continue those 17 projects, and it's looking good that we'll be able to have at least a small amount to carry us over for the next year.

We did create a website for those grantees, www.supportebhv.org, and I would encourage you to take a look, if you want to learn more about those projects and where they are and what they're doing.

Finally, I just want to mention, when we look back on our prevention work to date, what are some of the lessons that we've learned, and what are some of the things that we want to keep in mind as we go into the future of this work with home visiting? I think the

first thing is the importance of contextual change, certainly on the evidence-based home visiting implementation and local evaluation as a result of this funding, federal funding issue, obviously that affects all 17 projects. But even at the local level, many of the grantees have been very concerned about the economic crises and how that is affecting their ability to get the funding support from their partners that they had been promised but with, you know, state and county budgets, you know, downsizing, staff downsizing, there's been a real impact on not only just the number of families that they had hoped to serve, but also just to provide services, you know, in general.

The complexity of integrating home visiting models into local service networks, I think we're really learning a lot about that and it'll be interesting to listen to the model developers here in a few minutes. But, you know, there's the model and then there is the actual implementation in terms of, you know, what are we learning about the infrastructure that's required in a community to implement a specific model. What about scaling up? What about sustainability? We're learning a lot about those challenges. And again, I think this is important for us to keep in mind, you know, for the rest of the discussion.

The current 17 grants are designed as infrastructure building projects. They're really, that money really is not meant to go for direct services, it's really meant for those partnerships to work with each other and to share and to figure out what is the best way that they could work together to maximize the resources that the community does have available for the provision of high quality home visitation services.

And so the partnerships really are working on capacity building in terms of planning, operations, workforce development, qualify assurance, program evaluation.

The importance of establishing rigorous evaluation standards and implications for technical assistance needs and related resources, I think that whenever we start these large projects, we have technical assistance available, but we're never sure exactly who will need what. And so I think that they have this particular group of 17 has really demonstrated that they do need our assistance and they have taken advantage in order to, you know, work toward reaching the goals that they have set for themselves.

Something that we've done a lot in the last few years, along with this whole development of evidenced-based work, is really the importance of learning from each other and so we have set up peer learning communities, we have regular conference calls with the grantees, and you know, the feedback that we get from that is that that's probably one of the most valuable forms of technical assistance, is that ability to listen to their peers, learn from their peers and really talk about sort of, what is the commonalities, what are some of the challenges that we're facing together, separately, and so on.

And then I think finally, you know, what we've learned a lot about is this whole notion of transparency and the importance of maintaining open and honest communication, you know, as we go through the different challenges that arise and try to resolve them.

So that's kind of hopefully just a snapshot of some of the prevention work and specifically related to home visiting that we're doing at the children's bureau. Just on this notion of interagency, collaboration, I did want to mention that in August, August 2nd, or August 3rd through the 5th of 2010, we will be bringing together our prevention partners from across many agencies, grantees, and the early childhood systems building groups for a summit called Early Childhood 2010, Innovations for the Next Generation and so keep an eye out for information about that. I think that would be a great opportunity for you to come and participate, that will be here in Washington, as I say, here in August.

So that's all I have, thanks very much. It's great to be here and enjoy the rest of your conference.

NAN STREETER: Katherine, thank you so much and I'm so glad that you're here with us to share what's happening at ACF and potential ideas for future collaboration.

I would now like to invite our panel of representatives to the stage and I will introduce them.

Peggy Hill is here, she's the Director of Program Development for the Nurse Family Partnership.

Sue Stapleton is the President and CEO of the National Center for Parents as Teachers.

Marvin Schwartz is the Executive Director of HIPPY, and for those of you who don't know what HIPPY is, it's Home Instruction for Parents of Preschool Youngsters USA.

Sarah Walzer, Executive Director of the National Parent Child Home Program.

And last but not least, Cindy Wessel, the Senior Director of Healthy Families America.

So as we did yesterday, each panel member will take about five minutes to share a quick overview of their particular model and then we'll discuss some of the big issues that are raised by home visitation and what we need to know as MCH leaders.

PEGGY HILL: Okay. Good morning everyone. I appreciate the opportunity to join my colleagues here and address all of you, it's been really fun the last couple of days to reconnect with some of you who have been involved with evidence-based home visiting and nurse family partnership in particular, as well as the programs that are led by my colleagues here.

Going to give you a really brief overview, as requested, of Nurse Family Partnership, and it takes so much more planning to do five minutes than an hour, doesn't it? So I actually have notes, I never use notes.

Nurse Family Partnership is a home-based nursing intervention that currently works with about 20,000 families nationwide. We've been growing slowly over the course of about the last 10 years and we're in 29 states right now. We enroll women who are pregnant for the first time and living in poverty and the approach that our nurse home visitors take is number one, very practical, it's behaviorally-focused, flexible, family centered, starts to sound a lot like maternal and child health practitioner. Think, okay, you recognize these phrases.

Our approach is fundamentally about health promotion with health defined quite broadly. And we methodically go about the process of identifying the strengths that are inherent in each individual woman who enrolls, their families, however, they define their family, and the surrounding neighborhoods and communities in which they live, which are, of course, tremendously diverse.

The program does have three common goals, no matter where it appears across the country, that we share with all the young families that can work with us, and that is to help every woman have a healthy pregnancy, prepare to give birth to a healthy child, then to work with parents or their grandparents, or whoever the caregivers are for that new baby, to make sure each baby develops well, becomes healthy, stays healthy, and enters school appropriately, ready to learn because of healthy development.

And then third, we work with every young family on their own vision for the future, their own capabilities to finish school, find work, become economically self sufficient, because that's truly the foundation for ongoing stability.

The program has been rigorously tested through a number of studies, I think the core research consists of three randomized controlled trials that our founder, Dr. David Olds, began back in the 1970's. Those three studies were conducted in different settings with different populations, different timeframes, and each one has been followed longitudinally to discover whether or not the program had effectiveness and whether or not the outcomes of the programming, each of those settings with each of those populations was sustained over time.

The results have been really encouraging, which is why many of you have expressed interest in it. We do, indeed, reliably improve women's health during pregnancy, we're reliably nurture the development of young children, including reducing injuries to children, reducing developmental delays and problems associated with kind of the early emergence of mental health diagnosable mental health conditions and so on, and we reliably improve the economic well being of families. Primarily through helping families become employed more often and for longer, to plan subsequent pregnancies, increase the spacing between first and second pregnancies, and all together, just get on that healthy trajectory that we want them to stay on, and they do stay on for a very long time.

The program costs about $4,500 per family, per year, and again, it's up to a two-year intervention plus pregnancy. And the cost return in independent economic evaluations has indicated roughly $17,000, $18,000 return net above the cost of the program, which has again been motivating for a number of people who, across a number of agencies that need to see that cost value, as well as the social and health value.

The Nurse Family Partnership National Service Office exists primarily to deal with the challenge that Katherine noted, which is, you can develop a model that's demonstrated to be effective and reliable in its research testing, but moving it into practice with hundreds and hundreds of different partners in local communities and states, it's a little bit a throw of the dice.

So our office exists to provide the necessary structure, to move that program into practice, again, flexibly, but reliably through community and state policy planning, education for the nurse home visitors and supervisors, and an information system that's really focused on evaluation and quality improvement for the long haul, that really equips every local program to be partners with us in managing quality.

So again, we've steadily grown, we're not as widespread as some of my colleagues' programs here, but we're delighted to be in partnership with all of you in maternal and child health.

NAN STREETER: Thanks, Peggy, and now we'll turn to Sue.

SUE STAPLETON: Great, thank you very much, Nan, and I totally concur with Peggy, it is so much easier to talk 60 minutes with the full Power Point than it is to talk briefly, so I, too, am speaking from notes. And the things I leave out that you're interested in, Booth 304 is staffed and ready, so good see it, you'll get the footnotes and the full model there.

Parents is, well, first, first I want to use 30 seconds of my allotted time to speak kind of to Audrey and Katherine and I'm not lobbying you, I'm supporting the things that you have said in terms of how the guidance gets written and we're all waiting with baited breath and not shy about giving our input and some of the things that we're very concerned about, it's been very encouraging to look at the spirit of collaboration that has been growing, it's great for those of us who come to Washington periodically.

I'm a little bit concerned, I'm more than a little bit concerned, about how that's going to translate to the states and how that spirit will translate to the states so that I'm looking forward, and I think have assurances from both of you, that the guidance will get written to emphasize the need for that collaboration among departments of the state. I think it's tremendously important that states be given choices among the evidence-based models. In terms of evaluation, I can again only lift up, we really need to figure out some things beyond, does this model work, does this model work, does this model work? We all know our models work and we have substantial bodies of evidence to verify that.

Let’s look at, we’re using the terms these days, active ingredients of the home visiting programs. What are the essential things that we need to do? Implementation studies, replication studies, things of that kind. So that’s all, now.

We really appreciate the chance to look at parents as teachers from the frame of health and health outcomes. We’re primarily known as school readiness, but our definition throughout our 25 year history of school readiness, has meant among other things, school healthy. It means that kids hopefully are born as a result of healthy pregnancies and in our case, whichever pregnancy that is. We mean that kids are immunized, we mean that kids had been screened early, and regularly, and complimentary to well baby screenings. These are developmental screenings, hearing and vision, and extremely important, social emotional, so that when kids are on the doorstep of school, they’re ready in all of the domains, and that’s where our partnership with you is so important. Last year we screened 200,000 children, uncovering 60,000 delays. Think about the savings if we keep those kids out of special education, if we keep them out of your clinics after you have done what you need to do.

The results, we have powerful school-readiness results, particularly relating to poor children. Also, perhaps as relevant for all of you, is the parent outcomes. Parents who participate in Parents as Teachers are more knowledgeable about behavior management up to and including discipline, they create better home environments, more appropriate home environments, and as we have all begun to think about the concept of medical homes, we think we can be powerful partners with you in helping

support and carry out those medical homes. Parents are less likely to be subjects of abuse and neglect and so forth.

Our model briefly, it is based on research, very carefully prepared curriculum that looks at all the domains of children's lives, that's revised every few weeks—few years, I'm sorry, God, no. It is our staff, our professionals, two-thirds of them have at least a Bachelor's degree and a solid 30%, 20-30% have Master's degree in sometimes early childhood, most frequently, sometimes in social work, some time in nursing or other appropriate disciplines. So they're a professional staff delivering the services. They also match the communities in which they serve.

We're particularly happy with our track record in terms of working with Native American families, which we do a great of, and most of those parent educators are Native Americans themselves, who are fluent in both the culture and the language.

Again, entry point for families is any pregnancy and anywhere along the continuum from pregnancy through entry into school level, so obviously those we see earlier, those we see for the longest periods of time, can be expected to experience the greatest benefit, but they can get in any time, the portal is open.

A hallmark of our work in communities, as many of you know, I think, and again, picking up the themes that were sounded earlier, is collaboration. That has always been the

way in which we work, that is the way we're tremendously excited about thinking about new ways to do this.

When a program is Parents as Teachers, they must be carrying out the four elements of the model, they must adhere to our quality standards that are based on best practices, from all of our models, they must have accountability for parent educators and their ongoing training, but within that, our partnerships are with public health, I've observed one myself that was tremendously encouraging in Kansas City, a year or so ago, where the parent educator is actually in the clinic with the pediatrician sitting in the waiting room with parent and child, going into the little waiting area, the examination room, with the parent and the child, waiting for the healthcare professional, and using that time to educate, support, gain observations that help support the healthcare professional's observations and treatments and diagnoses. This is a powerful partnership and we'd like to see more of that.

We're also frequently in collaboration with others of your community partners, Headstart and Early Headstart frequently, child care, and again, I mentioned special work with both Native Americans and military families.

Quick word about evaluation as I finish my brief time, there have been 14 independent evaluations of Parents as Teachers in different aspects, the evaluations—we don't do our own evaluation, that's carried out by independent researcher, sometimes universities, most recently Case Western Reserve, sometimes think tanks, sometimes

individuals, we look at evaluation always as a chance to get better, to do better work, and that applies whether we like the results of the evaluation or whether we don't so much like it, it's a chance to get better and learn more about Parents as Teachers, which we are proud to say is a constantly evolving production.

Our research typically looks at a variety of research designs, we believe, as do many, many well-respected researchers, that there is much to learn from a variety of respected evaluation techniques.

We are, just a sidebar real quickly, in addition to the core program of Parents as Teachers, which is the main subject of our discussion today, we've also developed a more generally available curriculum around health and wellness for very young children, including infants and young children. We were astounded to find out how little has been written in the worlds in which we most typically inhabit about those things regarding infants and very young children beyond some, that are in the common literature. So you might be interested in that, I think that can also, you can get more information about that.

Let me close just by saying we're very excited about this meshing of, from the departmental level to the communities where we already work closely together with all of you. We look forward to that increasing as whatever happens with the home visiting.

And I want to say, beyond the legislation, whatever happens with the legislation, the dialogue, the thought processes that have gone into trying to get the thing passed, but they will lead to fruitful endeavors together for kids and families across the years, and I'm trying to stay focused on that regardless of what happens in the interim. Thank you.

MARVIN SCHWARTZ: Good morning. Am I on? I am, okay. Well, when you have a name like HIPPY, a quirky name like that, you're used to a lot of jokes about granny glasses and beads and tie-dyes, and it's a good opportunity to really tell what the program is about and since Nan had to identify what our acronym is, we are somewhat of an adjunct agency to the health environment. HIPPY is a school readiness and early literacy program similar to Parents and Teachers in our unique way. And so I'm delighted to be part of this conversation because we represent another perspective on how to develop a healthy family. And the common line between us, and my mantra in any public program is essentially this, that a healthy child is a better learner and a healthy family will produce a healthy child. We're all focused on that.

The HIPPY model, I'll give you a bit of a quick history and tell you how we fit into this environment today. We started in Israel, in the late 1960's, the national government was bringing in Jewish families from North Africa from the Middle East, bolstering the population. There was an educator at Hebrew University that recognized that these families, coming from extraordinarily primitive conditions, tribal conditions, were not going to be ready, their children were not going to be ready to mainstream into a fast-paced, Western-style democracy that Israel was becoming. And she developed a home

visiting outreach program to take a member of the same immigrant community who was a step up, a little more assimilated, a little bit more culturally advanced than their peers, train that person with a highly scripted curriculum, send that person into the home, and sit at the table, and it's always with the moms, sit at the table with the mothers, in our contemporary vernacular, we'll call that a sister friend, who sits at the table and in a sense of role playing, will share a sense of capacity development with the parent.

What HIPPY does today is the same as what started in Israel nearly 40 years ago, we came to the US in the mid 1980's, as a result of support from the National Council of Jewish Women, the NCJW sponsored the institute that delivered the program in Israel, brought the program to the US, there were communities in the US that had substantial Jewish populations and were the original sponsors of the program, remarkable synergy occurred, one of those early programs was in Miami, Florida, Miami Dade School District, continues as our oldest ongoing HIPPY program in the country, and the National Governor's Conference took place in Miami in 1986 and some of you may remember who was the Governor of Arkansas in the 1980's? So Bill and Hillary were in Miami and Hillary saw a little note in the paper, it was a recruiting a HIPPY staff or a HIPPY family for some type, tore it out, gave it to her staff, said, "Go find out what this is about." And in her wisdom, saw that what worked with an immigrant families in a foreign country such as Israel, would have an immediate application to the rural poverty, the African-American poverty of the Arkansas Delta, which is in some cases, close to a third world condition, and she was exactly right. And the Clintons adopted the program and gave it an enormous push, it was HIPPY with a capital C in those early days, and when

you have a support on that level and particularly when they took it to the White House, HIPPY had an opportunity to really grow in strength and establish itself as preeminent early childhood development organization. Our focus again is on school literacy, excuse me, school readiness, and early literacy.

We work in the home, we work with the parent, we empower the parent to teach the child. Now, this is an extraordinary component and it speaks to the essence of home visiting and why it is a valuable medium for all of our service programs. When your agent, when your service outreach person goes into the home and sits at the table with that parent, you're doing several things. First of all, you're honoring the home environment and you're crediting that person with doing the best they can. We are all working primarily with disadvantaged families, there may be language barriers, there may be economic, educational barriers. These are disenfranchised, marginal families. In general, the world has not been particularly kind to these people. They have been told you can't achieve much, you've never achieved much, and you certainly can't do much for this young, little person running around at your feet.

And so there's a sense of helplessness, there's a sense of lack of worth in these homes. By sitting at the table and teaching that parent to be aware of, or to use certain skills or to utilize a very scripted program, we're building a capacity in this parent and saying, "You can do something remarkable," for yourself, on the first level, this is a transformational experience that says, "You have the capacity to teach someone else, even though you don't have an education."

And then secondly what HIPPY does, is we direct that new capacity toward the most important person in that child's life, in the parent's life, the child. So we're giving the parent two enormous step ups in their whole sense of who they are. They can do something important for the first time in their life, something positive, and they can direct it to the most important person in their life, their child. This is, as Oprah, says, a transformational experience. And it gives the parents a sense of a remarkable capacity.

That capacity then, of course, we follow the child in school, we have longitudinal studies to show the impact and the education achievement. But I want to bring us back to the parent and the household because that's where the link to health programming comes in.

Just as Sue said, we see results in the parent in, 1) school engagement, this parent will follow the child through the school years and be more involved in that experience. There will be a reduction in health problems in the home, less abuse, less neglect, less trauma, there will be a healthier family.

And third, and a very interesting concept is work force development. The parent who engages in the HIPPY program and learns through a scripted process to keep track of activities, to record activities, to define themselves through a daily work plan with the child, becomes ready for their first job experience and they go on to adult literacy programming, GED programming, they get their AA degrees, and where the

opportunities exist, they become the next generation of the home visitors who go into the home on behalf of the HIPPY program.

So there's a remarkable opportunity in scaling up of the program and we have, of course, wonderful stories of former, subsistence level parents who are now school teachers and may level, an even PhD level educators, and it's an excellent testament to the impact of the program on families.

We see the opportunity to deliver, and HIPPY is acting on this opportunity, to deliver adjunct services that link the home visiting experience, the educational delivery, to health awareness and health programming. So we have a health literacy program that is being implemented in the State of Florida that is getting a lot of success and state support. Teaching parents through the home environment and through group meetings, that there are larger issues related to the health of their child, immunization, dental, etc. Home health issues, lead paint, other factors.

We're also introducing a nutritional program, teaching parents and children to cook together, so that they can prepare healthy foods and address childhood obesity and diabetes and other issues that are a critical stage cross country.

HIPPY is an excellent partner relationship with another very, very common form of early childhood development. We are a home-based, home-strategy program, Headstart and

others are center-based programs. There's the opportunity to link a center-based and a home-based strategies to create a full outreach into the community.

And my favorite among the work that I'm most exciting about structuring, is find the way to link maternal and child health programs to school readiness and early literacy and create this wonderful, but mysterious 0 to 5 continuum that everybody wants to see happen and we're all struggling **** everybody wants that to happen. And every administrator and every federal agent will tell you, leverage those existing resources, put to work what's already in place, HIPPY and Headstart, HIPPY and Nurse Family Partnership, HIPPY and Parents as Teachers, whatever the program models are, we can work together. So, we'll talk more about that as the morning goes on, but that's what HIPPY's about.

SARAH WALZER: Hi, I'm Sarah Walzer and I'm Executive Director of the Parent Child Home Program and I'm delighted to be in this room full of people who are getting ready for when that home visiting dollars descend into our communities.

The Parent Child Home Program is also a school readiness, early literacy model. It has been working with a number of my collaborators on the stage in partnership because we pick up children as they turn age two and work with them for two years before they enter what would be the next quality educational step in their community, either Pre-K or Headstart. We define age two, as starting as young as 16 months, depending on what

the precursors are in the community, and also at what age the child will be able to move into the next phase.

The focus of our program is uniquely on parent-child interaction. In fact, for the first 30 of its 45 years of existence, the Parent Child Home Program was known as the verbal interaction project, and in fact, many of the research studies on the program are published under that name.

The originator of the program was challenged in 1965 to come up with a high school drop out prevention program, and being a woman before her time, she announced to her dissertation advisor at Columbia Teachers College, that the real way to prevent children from dropping out of high school was to make sure that when they were two and three, they had a strong quality, quantity, verbal interaction relationship with their parent or primary caregiver. And so she set out to design that program and really for the first 30 years of this model, it was a research project in action because the first phase was to actually implement the program with parents and their two and three years olds. The second phase was to follow those families as those children entered school, to see if in fact you were seeing the outcomes when they entered school, from that quality and quantity of verbal interaction. And the next phase was to wait 18 years to see if they actually graduated from high school and went on to college. And we did that and we actually know that children who participate in this program, through randomized evaluations, go onto graduate from high school at the rates of middle class children nationally.

Like my partners on the stage, our target population is low income families, particularly in our case, families who have language and literacy barriers. We work a lot with parents who are illiterate or have very limited literacy skills. We work with families speaking 85 different languages and dialects across the country. And our focus is on getting them to read and play with their children during the two years that our home visitors are in their home twice a week.

Like HIPPY, our home visitors are paraprofessionals from the communities in which these families live. 40% of them are parents who have participated in the program as parents and go on to enable us to build this core of home visitors who speak 85 languages and dialects. And their focus in those twice weekly home visits, is with that parent and child, together in the room, our research all talks about working with the dyad and I spent a lot of time when I arrived telling our staff they couldn't use that word dyad in public because nobody knew what they meant, but it is that parent and child and we define parent as being the grandparent, foster parent, aunt, uncle, mother, father, whoever is the primary caregiver in that child's life. The focus is on working with them together on interacting around a series of books and toys that are the curricular material of the program. Each week that home visitor brings a gift of a book or toy into the home, often, in fact in most cases these days, the books that we bring into the home are the first books in the homes of the families we work with. Not just the first children's books, but really the first reading material. The books, if at all possible, are bilingual in the family's native language, and the emphasis for the parents is on how you use that book

whether you, yourself have literacy skills. Your two year old doesn't know if you're talking about the pictures on the page or reading the words that are written there. What they want is the experience of sitting on your lap, looking at a book, talking about it, which builds their vocabulary, builds the parent's vocabulary, and develops the skills this child needs to enter a classroom.

When I talk to folks who don't know, young children and their parents about the program, what I often ask them to imagine is, imagine what it would be like to walk into a pre-K or kindergarten classroom the first day and have the teacher tell you to get a book from the book corner and sit at your table and look at it, only you've never held a book before, you've never turned the pages, you don't know even which way to put it down on the table.

The next thing the teacher does is tell you to take a puzzle from the puzzle corner and start working it and you've never seen a puzzle before and you don't know what to do with all those pieces. Then the teacher sits everybody in a circle on the carpet and reads a story, only you've never been asked to sit still and listen to a story before. You never engaged in a conversation with an adult or other children about a story before. You've just failed your first day of kindergarten and you feel like a failure and that sticks with you through the rest of the educational process. What we know is that children who enter pre-K and kindergarten, not prepared to be in that classroom, are the children who can't read up to standard when they get to third and fourth grade. And children who can't read in third and fourth grade are the children who don't graduate from high

school. So in fact, Dr. Levinstein was right in 1965 when she said, “If we can go into homes and work with parents and their children to get them ready to enter school successfully, we will be able to see them graduate from high school.”

So we are delighted to be here, we have sites in 15 states around the country, in a number of states, our sites are actually housed in hospitals or community health centers. So at the grassroots level, we’ve already started that process of building the continuum with maternal and child health folks across the country and we really look forward to continuing it as we move forward using the federal money that is soon to arrive on all of our doorsteps.

CYD WESSEL: Hi, I’m Cyd Wessel, I’m the Senior Director of Healthy Families America and there’s always a benefit and a detriment to going last. Clearly the benefit is that many of my colleagues have said things that are very similar to Healthy Families, and a detriment in that most of you have cold coffee and now are wondering how quickly you’ll be able to use the restroom.

So at this point, I’m going to shift up my presentation a little bit to talk about some of the similarities and the differences of Healthy Families America, particularly in relationship to Nurse Family Partnership and parents as teachers, because we all began providing services prenatally to the families that we work with. And so when we often look at, and we kind of have joked about the road show we’ve been on for the last six to eight months, as, you know, home visitation has taken a forefront in many discussions

because of the federal budget, that when we look at them, how can we decipher, you know, Nurse Family Partnership tends to be funded through a health, a health-type of funding source. Parents As Teachers through an education, as Sue said, you know, they're often put into the school readiness piece, and Healthy Families, because we're housed through Prevent Child Abuse America, tend to be put into the child abuse prevention category, or as we're even referring to it now, infant mental health. But if you look at each of those three circles interconnecting, we certainly all have a school readiness or literacy aspect, we all have a health aspect, and we're certainly all about promoting positive infant mental health.

So what makes them different and how can we benefit from this continuum? We, much like Parents As Teachers, have home visitors who typically have a Bachelor's degree or some college, and in some cases, Master's degrees. We also have home visitors, it's interesting, I've been getting a lot of calls lately, of, you know, can nurses work for healthy families and we certainly have nurses who are providing the home visiting services. But I think when you look at the different models, there have, some stereotypes have filtered into that as to what the expectations are.

We also have often been pigeonholed as being the paraprofessional program in that our home visitors are not necessarily degreed or educated in a manner and in some ways, I feel that's a real disrespect to the home visitors in our network because they really are professional positions and many of the people that are hired, are hired because of the

life experiences they have that have allowed them to really be able to connect and work with families in an intimate setting, their home.

And so what we've found is that it's not as much important what that previous education or background is, but what is your ability to go in and build a positive, nurturing relationship with families that's going to impact them over the long haul.

We also differ in that we do not necessarily prescribe or state who the program needs to serve. We suggest that they do a community assessment. Do they have a high rate of teen pregnancy and is that something that they want to address? Are they finding that subsequent pregnancies, you know, as Peggy mentioned, maybe they're coming close together, they have three or four children in the home. And so the programs can really determine whether they want to use funding to support first time parents, parents with more than one child, and what we also find is that many of those programs have what we call a patchwork quilt of funding, that they have diversified funding so that they can continue to provide services to a multitude of different family characteristics.

We also do not have a specific curriculum that is used for families. Again, the program is allowed to determine what curriculum, we have very strict best practice standards around that, but they can choose the curriculum that they want to go in and use in the home with the family, that best meets the needs of that particular family. The most commonly used curriculums in our network are Parents As Teachers, which is probably the most widely used, and we also have one that is also growing, called Growing Great

Kids, obviously growing and growing great kids. But they have created a curriculum that is specific to working with families that are most overburdened, which to us, well, we would love to provide services to all families and some of our programs do, our programs are required to create some sort of systematic approach to determine who they're going to serve. And it's through this assessment that they look at families most in need and who are most likely to benefit.

And that assessment looks at very common risk factors, their childhood history, their history of substance abuse, mental health, and criminal backgrounds. Looks at their social support, who do they have as a life link? Who can they go to and trust to be there for them? What are their biggest concerns in having a baby or leaving a hospital with a baby? What type of potential do they have for partner violence or domestic violence or anger management? And along with that, we're also looking at a variety of things related to their preparing for parenting as well as maybe they're expectations of parenting.

From there, what we have found, and I think the State of New Jersey, as I look here and we look at, you know, as Marvin was saying, this continuum of home visiting, the State of New Jersey, which for us was actually one of the evidence-based home visiting locations that was chosen for the research grant, looked at how Parents As Teachers, Nurse Family Partnership, and Healthy Families America in particular, can use this assessment to determine which program best meets their needs and that's what they're looking at, how do we create a single point of entry and from there, determine which

program best meets the needs. First time teen parents, it's pretty much, you know, a no-brainer that Nurse Family Partnership would be an excellent fit, but in some cases, or in many cases, programs are full, in which case Parents As Teachers or Healthy Families might also be a fit for that particular parent. And again, if it's a family with more than one child, maybe Parents As Teachers or Healthy Families is the venue with which we serve them.

And so I think that we have to continue to look, you know, based on pots of money, where the funding comes from, how do we serve our families? The outcomes really do all impact each other. A healthy child equals a school-ready child. And so I think that we all really benefit by continuing to come together.

In Healthy Families, our bet infrastructure is what we call our multi-site systems, which makes up about 75% of our network and our multi-site systems are a grouping of sites in a state typically where there is a central administration providing training, technical assistance and support, oversight, and some type of external evaluation. Like Parents As Teachers, we've had many studies, actually over 40 at this point, where they have predominantly been quasi-experimental, but we do have randomized control trials and interestingly enough, leading up to this, which transitions me into the final part of my talk, is that, you know, we need to start addressing the major barriers to being successful, and you know, in the home visiting field, we refer to those as the big three, intimate partner violence, substance abuse, and mental health issues. We had a longitudinal study that was just released regarding our Hawaii Healthy Start Program

indicating a decrease in intimate partner violence among the families that were being served. Soon we will have a 10-year follow-up study to that longitudinal, randomized control trial that will also show that amongst third graders, the families that participated in Healthy Families, had a decreased incidence of maternal depression.

The substance abuse continues to be a huge barrier for all of our programs and we currently, where we're positioning ourselves in the next five years is to prepare our network of more than 3,000 home visitors to better serve families who are experiencing substance abuse, domestic violence, or mental health issues, and in many cases, all of the above at the same time. And so we're actually looking to create a partnership with those treatment organizations to create some sort of seamless process so that home visiting can be a support to the success of families receiving the treatment they need to get back to that parent-child relationship and positive infant mental health.

So that is my five minutes, or ten.

NAN STREETER: Well, one thing I think you all learned is how you can talk about your programs in five minutes, so you have a new skill, right?

I'm impressed with the variety of different programs and I think that certainly is going to help Title V programs to get a better sense of the various options that are available.

And what I would ask you is, in your experience, what is it that Title V programs and states could do to work with your programs? How to implement, etc.? Because I know some programs are more structured than others and I know in Utah, for example, we have a couple of programs in the, you know, community. So I'm just curious to hear what your view is of working with Title V programs.

PEGGY HILL: I just would start by saying the vast majority of the agencies that host Nurse Family Partnership now are public health departments with either direct, some direct funding from maternal and child health or Title 5, or really close partnerships with the other kinds of initiatives that are focused on health promotion through Title 5. So there's a fairly natural fit there.

In addition, one of the things we love to do intentionally with Nurse Family Partnership, is identify the skill sets and backgrounds of the nurses that come in as nurse home visitors, and supervisors, and identify the other specialty areas of expertise that may be part of the public health system, or that may exist in other agencies in the community to create kind of an interdisciplinary team of other professionals who can either augment the training and ongoing professional development that the nurses have, and provide multidisciplinary input to case conferencing, around particularly challenging family situations. So by hosting the program, by co-funding, providing expertise and resources from other MCH programs, we like to nest in that, in your contact, so thank you.

UNKOWN SPEAKER: The other thing, if I might take over there, is one of the things we continually discovered is the field's way ahead of us and there are already best practices out there where the funding meshes, the I hand off to you, or you hand off to me, or we all work together, and so we're not starting over. While you have the wonderful task of writing the guidance and we have the task of trying to be sure our programs have the right spirit about cooperation and collaboration, as well as the information they need, I think we are in a process for all of us, of saying it's not about one approach by any means. So just as I think we've all gone through the exercise this morning, those of us who don't live primarily in the health field, of saying, well, what are the commonalities that are already there? Let's get those, let's build on what we already know, where there are good examples of the work together communities. And, I guess, as we are trying to broaden the perspective of our organizations, you all will be doing the same thing from both your perspectives and the state perspective, to say, let's be sure we're all looking external, we've all said something about how the health outcomes are so critical to kids doing well in school and I think that we just all need to be putting ourselves in the mindset that that's where we need to be going.

MARVIN SCHWARTZ: There's an opportunity, an example, in the new immigrant population, Latino families, for example, who will consider the medical services, health services in their home communities. There are walk-in doctor's offices and you pay for your services and it's a very common and easy responsibility for the parent to fulfill. IN this new world that they come to in America, the relationship with the doctor is a very foreign and difficult environment and a situation to negotiate. And they don't know how

to do it and calories are cheap in America and children are getting larger, and people are, they don't know how to do these things, and yet they are all going to school. And so there's opportunities to bridge the educational link to a health program.

In the Arkansas Delta, for example, in the deepest poverty counties of southeast Arkansas on the Mississippi River, there's a health outreach program in place and the Department of Health came to Arkansas HIPPY and let us bridge with your home outreach workers, we'll take our health workers and your home visitors and reach those very marginalized families who don't know where the services are and introduce them to that continuum, in ways that work together.

UNKOWN SPEAKER: You must have read my mind, because that was going to be my next question, is how the programs work with different populations, particularly populations that are non-English speaking, because that's a real challenge for all of us.

UNKOWN SPEAKER: Well, I think the first way that you work with populations that are not English speaking is by having staff who speak their, not only speak their language, but come from their cultural background. We've been doing a lot of work, in the northwest, particularly in the Seattle area, where we have sites that are serving Thai, Cambodian, a range of East African families, and we found that the biggest challenge is recruiting staff who speak those families' languages, are able to develop the skills that we need them to develop in order to be home visitors, but once you do that, those sites have 100% retention rate over a two-year period, with the families they're working with.